

**AHCCCS Encounters - Allowed and Net Allowed (Approved) Amount Matrix for BHS Plans**

#	Amount Field	Form Type	837 Location	Rules/Notes
1	COB Allowed AMT	I/P/D	2320/AMT01 = 'B6' 2320/AMT02 = \$	4010 Institutional & Professional & Dental
2	COB Approved AMT	P/D	2320/AMT01 = 'AAE' 2320/AMT02 = \$	4010 Professional & Dental
3				<p>With v5010, the 2320 COB Approved and 2320 COB Allowed Amount segments were removed from the 837 Transactions.</p> <p>5010 Includes guidance to calculate the Approved amount. The process with which to select the appropriate values for AHCCCS to calculate the Health plan Approved amount has been challenging. It was identified that the calculation would only work for some plans and not others. As a result, AHCCCS will require that Health plans submit the amounts</p> <p>Definitions:</p> <p><b>Allowed Amount</b> What would have paid under FFS before other payer</p> <p><b>Final Net Allowed Amount (Approved Amount)</b> Final value of the encounter if paid as FFS after all other payments have been considered</p>
4a	HP Paid Amount	Inst	2320/AMT01 = 'D' 2320/AMT02 = \$	<p>Institutional</p> <p><b>FFS Claim</b> - HP Paid Amount = Final Net Allowed Amount <b>CAP Claim</b> - HP Paid Amount = \$0</p>
4b	HP Paid Amount	Prof Dental	2320/AMT01 = 'D' 2320/AMT02 = \$  2430/SVD01 = Payer ID 2430/SVD02 = \$	<p>Institutional &amp; Professional &amp; Dental</p> <p><b>FFS Claim</b> - HP Paid Amount = Final Net Allowed Amount <b>CAP Claim</b> - HP Paid Amount = \$0</p>
5a	Billed Charges (Total Claim Charge Amt)	Inst	2300/CLM01 = Patient Acct # 2300/CLM02 = \$	Institutional
5b	Billed Charges (Line Item Charge Amt)	Prof	2400/ <b>SV1</b> (service info) 2400/ <b>SV102</b> = \$	Professional

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5c	Billed Charges (Line Item Charge Amt)	Dental	2400/ <b>SV3</b> (service info) 2400/ <b>SV302</b> = \$	Dental
6a	Allowed	Inst	2300/CN101 = '09' (FFS) or 2300/CN101 = '05' (Cap)  2300/CN102 = \$	Institutional - Claim Level - report for each encounter - '09' = other – proposed to be used for FFS - Line Level segment does not exist for 837I (2400/CN1)  Example: CLM*01234567*31676.50***11 A 1**A*Y *****3 DTP*435*DT*201107020700 DTP*096*TM*1130 DTP*434*RD8*20110702-20110725 DTP*050*D8*20110701 CL1*3*4*03 PWK*OZ*BM***AC*DMN0012 <b>CN1*05*&lt;ALLOWED AMOUNT\$&gt;</b>
6b	Allowed	Prof Dental	<b>2400</b> /CN101 = '09' or '05' <b>2400</b> /CN102 = \$	Professional & Dental - '09' = other – proposed to be used for FFS - Report for each service line in the encounter  Example: LX*1 SV1*HC T1016 HN*26.25*UN*1***1**Y DTP*472*RD8*20110708-20110708 <b>CN1*05*&lt;ALLOWED AMOUNT\$&gt;</b> SVD*PLANID0812*0*HC T1016 HN**1 <b>CAS*CO*24*&lt;FINAL NET ALLOWED\$&gt;</b> DTP*573*D8*20110727

7a	Final Net Allowed (Approved)	Inst (Cap)	2320/CAS01 = 'CO' 2320/CAS02/05/08/11/14/17 (Trio) = '24' 2300/CAS03/06/09/12/15/18 (Trio) = \$	<p>Institutional - Claim Level – <b>Capitated</b>  <b>Capitated = Amount Paid \$0, use CAS*CO*24 segment</b></p> <p>CAS01 = Group code - 'CO' = contractual obligation  CAS02 (trio) – CARC – '24' = Capitated Agreement</p> <p>Example:  CLM*50210121739*6422.95***11 A 1**A*Y*Y  DTP*096*TM*1600  DTP*434*RD8*20120210-20120214  DTP*435*DT*201202100100  CL1*1*1*01  <b>CN1*05*&lt;Allowed Amount\$&gt;</b>  REF*EA*AC062796M0  HI*BK 29622  HI*BJ 2989  HI*BH 42 D8 20120214  NM1*71*1*PROVIDERLAST*PROVIDERFIRST****XX*1437194109  SBR*P*18*****MC  <b>CAS*CO*24*&lt;Final Net Allowed\$&gt;</b>  <b>AMT*D*0 (Plan paid \$0)</b></p>
7b	Final Net Allowed (Approved)	Inst (FFS)		<p>Institutional - <b>FFS</b>  FFS - Final Net Allowed Amount would not be sent; it is the same as the HP Paid Amount which was already reported</p> <p>Example:  CLM*50214120841*11190.26***11 A 1**A*Y*Y  DTP*096*TM*1200  DTP*434*RD8*20120214-20120221  DTP*435*DT*201202142000  CL1*1*1*01  <b>CN1*09*&lt;Allowed Amount\$&gt;, 09=Other/FFS</b>  REF*EA*1101071528  HI*BK 29690  HI*BJ 2989  HI*BH 42 D8 20120221  NM1*71*1*PROVIDERLAST*PROVIDERFIRST****XX*1538201779  SBR*P*18*****MC  CAS*CO*45*5412.6 (<b>CO*24 Final Net Allowed not used for FFS</b>)  <b>AMT*D*5777.66 (Plan paid )</b></p>

7c	Final Net Allowed (Approved)	Prof Dental (CAP)	2430/CAS01 = 'CO' 2430/CAS02/05/08/11/14/17 (Trio) = '24' 2430/CAS03/06/09/12/15/18 (Trio) = \$	Professional & Dental - Line Level - Capitated <b>Capitated = Amount Paid \$0, use CAS*CO*24 segment</b>  CAS01 = Group code - 'CO' = contractual obligation CAS02(trio) – CARC – '24' = Capitated Agreement  Example: LX*1 SV1*HC T1016 HN*26.25*UN*1***1**Y DTP*472*RD8*20110708-20110708 CN1*05*<Allowed Amount\$> SVD*PLANID0812*0*HC T1016 HN**1 (Plan paid \$0) <b>CAS*CO*24*&lt;Final Net Allowed\$&gt;</b> DTP*573*D8*20110727
7d	Final Net Allowed (Approved)	Prof Dental (FFS)		Professional & Dental - <b>FFS</b> FFS - Final Net Allowed Amount would not be sent; it is the same as the HP Paid Amount which was already reported  LX*1 SV1*HC T1016 HN*26.25*UN*1***1**Y DTP*472*RD8*20110708-20110708 <b>CN1*09*&lt;Allowed Amount\$&gt;, 09=Other/FFS</b> SVD*PLANID0812*21*HC T1016 HN**1 (Plan Paid \$21) <b>CAS*CO*45*5.25 (CO*24 Final Net Allowed not used for FFS)</b> DTP*573*D8*20110727

8a	Denied Encounter example	Prof Dental	Allowed and Net Allowed amount does not apply	<p>Professional &amp; Dental - Line Level  CN1="05" or "09" does not apply for Denied Encounters  CAS01 = Group code - 'CO' = contractual obligation  CAS02(trio) – CARC – '24' = Capitated Agreement, not used  Use applicable Claim adjustment reason code for denial</p> <p>Example:  LX*1  SV1*HC T1016 HN*26.25*UN*1***1**Y  DTP*472*RD8*20110708-20110708  SVD*PLANID0812*0*HC T1016 HN**1 (Plan paid \$0 (denied))  <b>CAS*CO*45*26.25 (Use of CO*24 does not apply)</b>  DTP*573*D8*20110727</p>
8b	Denied Encounter example	Inst	Allowed and Net Allowed amount does not apply	<p>Institutional - Claim Level  CN1="05" or "09" does not apply for Denied Encounters  CAS01 = Group code - 'CO' = contractual obligation  CAS02(trio) – CARC – '24' = Capitated Agreement, not used  Use applicable Claim adjustment reason code for denial</p> <p>Example:  CLM*50210121739*6422.95***11 A 1**A*Y*Y  DTP*096*TM*1600  DTP*434*RD8*20120210-20120214  DTP*435*DT*201202100100  CL1*1*1*01  REF*EA*AC062796M0  HI*BK 29622  HI*BJ 2989  HI*BH 42 D8 20120214  NM1*71*1*PROVIDERLAST*PROVIDERFIRST****XX*1437194109  SBR*P*18*****MC  <b>CAS*CO*45*6422.95 (Use of CO*24 does not apply)</b>  <b>AMT*D*0 (Plan paid \$0 (denied))</b></p>
9				<p><b>Claim Adjustment Group Codes and common CARC usage:</b></p> <p>'PR' Patient Responsibility – Includes '3' Co-pay</p> <p>'OA' Other Adjustment – Includes '23' Other Payer paid amounts</p> <p>'CO' Contractual Obligations – Includes '45' Charge exceeds fee schedule, '24' Charges covered under a Capitation agreement</p>